

---

# Medicare

## Intermediary Manual

### Part 3 - Claims Process

---

Department of Health &  
Human Services (DHHS)  
Centers for Medicare &  
Medicaid Services (CMS)

Transmittal 1864

Date: OCTOBER 25, 2002

---

#### CHANGE REQUEST 2332

#### NOTE FOR FISCAL INTERMEDIARIES UNDER APPASS

Fiscal intermediaries under the APASS system have been given a waiver for the implementation of this instruction. Implementation will occur when APASS can update system or when migration to FISS occurs.

<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
3660.10 - 3660.10 (Cont.)	6-344.1 - 6.344.4 (4 pp.)	6-344.1 - 6.344.4 (4 pp.)
3660.20 - 3663 (Cont.)	6-344.6O - 6-334.6W (9 pp.)	6-344.6O - 6-344.6W (9 pp.)

#### MANUALIZATION--EFFECTIVE DATE: Not Applicable

Section 3660.10, Mammography Screening, is being updated to add revenue code 520 for federally qualified health centers (FQHCs) reporting of visits. This revenue code was inadvertently omitted from this section.

#### NEW/REVISED MATERIAL--*EFFECTIVE DATE: April 1, 2003* *IMPLEMENTATION DATE: April 1, 2003*

Section 3660.20, Diagnostic and Screening Mammography Performed With New Technologies, has been updated to clarify that both a screening film and screening digital mammography or a diagnostic film and a diagnostic digital mammography should not be billed together since payment will not be made for both. It also requires you to return claims to the provider when both a screening film and screening digital or a diagnostic film and diagnostic digital mammography are reported on the same claim.

In addition, this instruction allows for billing and payment of Computer Aided Detection (CAD) device in conjunction with new technology screening and diagnostic mammography services and requires installation of an edit to return claims to the provider when a CAD device is billed alone.

**DISCLAIMER:** The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

3660.10 Mammography Screening.--Section 4163 of the Omnibus Budget Reconciliation Act of 1990 added §1834(c) of the Act to provide for Part B coverage of mammography screening performed on or after January 1, 1991. The term "screening mammography" means a radiologic procedure provided to an asymptomatic woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure. Unlike diagnostic mammographies, there do not need to be signs, symptoms, or history of breast disease in order for the exam to be covered.

There is no requirement that the screening mammography examination be prescribed by a physician for an eligible beneficiary to be covered. Payment may be made for a screening mammography furnished to a woman at her direct request.

Prior to October 1, 1994, providers that perform screening mammographies must request and be recommended for certification by the State certification agency and approved by CMS before payment is made. Effective October 1, 1994, providers that perform mammography services (diagnostic and screening) must be issued a certificate from the Food and Drug Administration (FDA) before payment is made. (See §3660.16 for more detailed instructions.) A provider that arranges for another entity to perform a screening mammography for one of its patients must assure, prior to October 1, 1994, that the entity is certified to perform the screening, or on or after October 1, 1994, must assure that the entity has been issued a certificate by FDA. If the entity that performed the screening mammography is not certified, deny the claim utilizing the denial language in subsection G.

Section 4101 of the Balanced Budget Act (BBA) of 1997 provides for annual screening mammographies for women over 39 and waives the Part B deductible. Coverage applies as follows:

- o No payment may be made for a screening mammography performed on a woman under 35 years of age;
- o Pay for only one screening mammography performed on a woman between her 35th and 40th birthday (ages 35 thru 39); or
- o For a woman over 39, pay for a screening mammography performed after 11 full months have passed following the month in which the last screening mammography was performed.

A. Determining 11 Month Period.--To determine the 11 month period, start your count beginning with the month after the month in which a previous screening mammography was performed.

**EXAMPLE:** The beneficiary received a screening mammography in January 1991. Start your count beginning with February 1991. The beneficiary is eligible to receive another screening mammography in January 1992 (the month after 11 full months have elapsed).

B. Payment.--There is no Part B deductible. However, coinsurance is applicable. Following are three categories of billing for screening mammography services:

- o Professional component of mammography services (that is, for the physician's interpretation of the results of the examination),
- o Technical component (all other services), or

o Both professional and technical components (global). However, global billing is not permitted for services furnished in provider outpatient department, except for CAHs electing the optional method of payment for mammography services furnished on or after January 1, 2002.

Claims with dates of service prior to January 1, 2002, are subject to a payment limitation. When the technical and professional components of the screening mammography are billed separately, the payment limit is adjusted to reflect either the professional or technical component only. That is, the limitation (\$62.10 in calendar year 1996, \$63.34 in calendar year 1997, \$64.73 in calendar year 1998, \$66.22 in calendar year 1999, \$67.81 in calendar year 2000 and \$69.23 in calendar year 2001) applicable to global billing for screening is allocated between the professional and technical components as set forth by regulations. For example, in calendar year 2000, 32 percent of the \$67.81 limit, or \$21.69, is used in determining payment for the professional component and 68 percent of the \$67.81 limit, or \$46.12 is used in determining payment for the technical component.

Payment for the technical component equals 80 percent of the least of the:

- o Actual charge for the technical component of the service;
- o Amount determined for the technical component of a bilateral diagnostic mammogram (HCPCS code 76091) for the service under the radiology fee schedule in 1991; or for services furnished on or after January 1, 1992, under the Medicare physicians' fee schedule (MPFS); or
- o Technical portion of the screening mammography limit. This is an amount determined by multiplying the screening mammography limit (\$59.63 in calendar year 1994 by 63 percent, \$60.88 in calendar year 1995, \$62.10 in calendar year 1996, \$63.34 in calendar year 1997, \$64.73 in calendar year 1998, \$66.22 in calendar year 1999, \$67.81 in calendar year 2000, and \$69.23 in calendar year 2001) by 68 percent.

See subsection C below for payment examples.

For claims with dates of service on or after January 1, 2002, §104 of the Benefits Improvement and Protection Act (BIPA) 2000, provides for payment of screening mammographies under the Medicare Physician Fee Schedule (MPFS) for such services furnished in hospitals, skilled nursing facilities (SNFs), and in CAHs not electing the optional method of payment for outpatient services. The payment for code 76092 is equal to the lower of the actual charge or locality specific technical component payment amount under the MPFS. Program payment for the service is 80 percent of the lower amount and coinsurance is 20 percent. This is a final payment.

In addition, a new HCPCS code 76085, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography (List separately in addition to code for primary procedure)" for computer aided detection (CAD), has **been established** as an add-on code that can be billed in conjunction with the primary service screening mammography code 76092. Payment will be made under the MPFS. There is no Part B deductible. However, coinsurance is applicable. **(See §3660.20D for billing and payment of CAD when billed in conjunction with digital screening or diagnostic mammograms.)**

When a screening CAD (76085) is billed in conjunction with a screening mammography (76092) and the screening mammography (76092) fails the age and frequency edits in CWF both services will be rejected by CWF.

Return to provider claims containing code 76085 that do not also contain HCPCS code 76092 with an explanation that payment for code 76085 cannot be made when billed alone.

You were furnished with a mammography benefit pricing file via Program Memorandum (PM) A-104, CR 1811, dated August 23, 2001. Use this file to pay claims containing the above codes.

For CAHs, see §3610.22 for those that have elected the optional method of payment for outpatient services. Pay these CAHs for screening mammographies furnished on or after January 1, 2002 at 115 percent of the lesser of:

- o Eighty percent of the actual charges of the CAH for the screening mammography, including both the radiologic procedure and the physician's interpretation, or
- o Eighty percent of the global payment amount under the MPFS for the screening mammography.

C. Determining Payment Amount For Technical Component for Claims with Dates of Service Prior to January 1, 2002.--This provides for the payment calculation of the technical portion of a screening mammography. For services in 2000, pay the lower of:

- o Billed charges for HCPCS code 76092;
- o \$46.12 limit; or
- o The physicians' fee schedule amount for the technical component of HCPCS code 76091.

**NOTE:** For services in 1991, use the fee schedule amount for the technical component of HCPCS code 76092 (since there is no price for HCPCS code 76092, use the technical RVS (3.79) for HCPCS code 76091 and the conversion factor to determine the fee schedule amount).

The screening mammography payment is a final payment, not a payment limit, as are other radiology services, and is not subject to the radiology blend. Therefore, determine the payment in your system before remittance.

**EXAMPLE:** \$90.00 Provider charges;  
\$75.00 Physicians' fee schedule amount; and  
\$46.12 Technical portion of the screening mammography limit (68% of \$67.81).

Payment is 80 percent of the lower of:

- \$90.00 Provider charges;
- \$75.00 Physicians' fee schedule amount for the technical component; or
- \$46.12 Technical portion of the screening mammography limit.

To calculate the payment, select the lower of:

- \$90.00 Provider charges;
- \$75.00 Physicians' fee schedule amount for the technical component; or
- \$46.12 Technical portion of the screening mammography limit.

Pay 80 percent of the remainder. Do not apply the provider's interim rate. This is a final payment to the provider.

In this case:

$$\$46.12 \times 80\% = \$36.90 \text{ payment to the provider.}$$

To determine the patient's liability, multiply the actual charge by 20 percent. The result is the patient's liability.

In this case:

$$\$90.00 \times 20\% = \$18.00 \text{ (coinsurance).}$$

**NOTE:** This payment limitation does not apply to claims with dates of service on or after January 1, 2002.

D. Billing Requirements.--Providers bill for the technical component portion of the screening mammography on Form HCFA-1450 under bill type 14X, 22X, 23X, or 85X, using revenue code 403 and HCPCS code 76092, except for CAHs who have elected the optional method of reimbursement who bill the carrier on the CMS-1500 for the global amount. See subsection B for payment requirements. Separate bills are required for claims with dates of service prior to January 1, 2002. Providers include on the bill only charges for the mammography screening. Separate bills are not required for claims with dates of service on or after January 1, 2002. (See below for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).)

For claims with dates of service prior to January 1, 2002, provider-based RHCs and FQHCs bill the intermediary for the technical component and their carrier for the professional component of the screening mammography. Provider-based RHCs and FQHCs utilize bill type 14X, 22X, 23X or 85X as appropriate when billing the intermediary for this service. Independent RHCs and free-standing FQHCs bill their carrier for both the technical and professional components. Payment is made based on the limitation.

For claims with dates of service on or after January 1, 2002, the professional component of a screening mammography furnished within an RHC/FQHC by a physician or non-physician is considered an RHC/FQHC service. RHCs and FQHCs bill you under bill type 71X or 73X for the professional component along with revenue code 403 and HCPCS code 76085 or 76092. Payment will be made under the all-inclusive rate. Specific revenue coding and HCPCS coding is required for this service in order for CWF to perform age and frequency editing.

Payment should not be for a screening mammography unless the claim contains a related visit code. Therefore, install an edit in your system to assure payment is not made for revenue code 403 unless the claim also contains a visit revenue code (520/521).

The technical component of a screening mammography is outside the scope of the RHC/FQHC benefit. The provider of the technical service bills their carrier on Form CMS-1500.

The technical component of a screening mammography for provider-based RHCs/FQHCs is typically furnished by the provider. The provider of that service bills you under bill type 14X, 22X, 23X or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). The appropriate revenue code is 403 and the appropriate HCPCS codes are 76085 and 76092.

Payment should not be made for a diagnostic mammography unless the claim contains a related visit code. Therefore, install an edit in your system to assure payment is not made for revenue code 401 unless the claim also contains a visit revenue code (520/521).

The technical component of a diagnostic mammography is outside the scope of the RHC/FQHC benefit. The provider of that technical service bills their carrier on Form CMS-1500.

The technical component of a diagnostic mammography for a provider-based RHC/FQHC, is typically furnished by the provider. The provider of that service bills you under bill type 14X, 22X, 23X or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services.) The appropriate revenue code is 401 and the appropriate HCPCS codes are 76090, 76091 and G0236.

A new HCPCS code G0236, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography (List separately in addition to code for primary procedure)" for computer-aided detection (CAD), has been established as an add-on code that can be billed in conjunction with the primary service diagnostic mammography code 76090 or 76091. Payment will be made under OPFS for hospital outpatient departments, on a reasonable cost basis for CAHs, under the MPFS for SNFs, and under the all inclusive rate for the professional component provided in an RHC or FQHC. The Part B deductible and coinsurance apply. (See §3660.20D for billing and payment of CAD when billed in conjunction with digital screening or diagnostic mammograms.)

RHCs and FQHCs must report revenue code 401 and HCPCS code G0236 when performing this service. Payment is made as described above for diagnostic mammographies.

Return to provider claims containing code G0236 that do not also contain HCPCS code 76090 or 76091 with an explanation that payment for code G0236 cannot be made when billed alone.

You were furnished with a mammography benefit pricing file via Program Memorandum (PM) A-01-104, dated August 23, 2001, CR 1811. Use this file to pay claims containing the above codes.

For CAHs, see §3610.22 for those that have elected the optional method of payment for outpatient services. Pay these CAHs for the professional component (PC) of the diagnostic mammographies furnished on or after January 1, 2002 at 115 percent of the lesser of:

- o Eighty percent of the actual charges of the CAH for the physicians interpretation of the diagnostic mammography, or
- o Eighty percent of the PC determined under the MPFS for the diagnostic mammography.

3660.20 Diagnostic and Screening Mammograms Performed with New Technologies.--Section 104 of the Benefits Improvement and Protection Act 2000, (BIPA) entitled Modernization of Screening Mammography Benefit, provides for new payment methodologies for both diagnostic and screening mammograms that utilize advanced new technologies for the period April 1, 2001, through December 31, 2001.

Payment restrictions for digital screening and diagnostic mammography apply to those facilities that meet all FDA certifications as provided under the Mammography Quality Standards Act as described in §3660.16.

A. Payment Requirements for Claims with Dates of Service on or After April 1, 2001 through December 31, 2001.--Providers billing for the technical component of screening and diagnostic mammographies that utilize advanced technologies use one of six new HCPCS codes, G0202 - G0207. See below for how payment for each of the codes will be determined during the period April 1, 2001 through December 31, 2001. Payment for codes G0202 through G0205 are based, in part, on the MPFS payment amounts. The amounts that are based on the MPFS that you will need in calculating the new payments for these codes were furnished to you in a BIPA mammography benefit pricing file for implementation on April 1, 2001.

o HCPCS code G0202, Screening mammography producing direct digital image, bilateral, all views. Payment will be the lesser of the provider's charge or the amount that will be provided for this code in the pricing file. (That amount is 150 percent of the locality specific technical component payment amount under the physician fee schedule for CPT code 76091, the code for bilateral diagnostic mammogram, during 2001.) Deductible does not apply. Coinsurance will equal 20 percent of the lesser of the actual charge or 150 percent of the locality specific payment of CPT code 76091.

o HCPCS code G0203, Screening mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views. Payment will be equal to the lesser of the actual charge for the procedure, the amount that will be provided in the pricing file (which represents 68 percent of the locality specific global payment amount for a bilateral diagnostic mammography (CPT 76091) under the physician fee schedule), or \$57.28 (which represents the amount of the 2001 statutory limit for a screening mammography attributable to the technical component of the service, plus the technical portion of the \$15.00 add-on for 2001 which is provided under the new legislation). Deductible does not apply. Coinsurance is 20 percent of the charge.

o HCPCS code G0204, Diagnostic mammography, direct digital image, bilateral, all views. Payment will be the lesser of the provider's charge or the amount that will be provided for this code in the pricing file. (That amount is 150 percent of the locality specific amount paid under the physician fee schedule for the technical component (TC) of CPT code 76091, the code for a bilateral diagnostic mammogram.) Deductible is applicable. Coinsurance will equal 20 percent of the lesser of the actual charge or 150 percent of the locality specific payment of CPT code 76091.

o HCPCS code G0205, Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views. Payment will be equal to the lesser of the actual charge for the procedure, the amount that will be provided in the pricing file (which represents 68 percent of the locality specific global payment amount for a bilateral diagnostic mammography (CPT 76091) under the physician fee schedule), or \$57.28 (which represents the amount of the 2001 statutory limit for a screening mammography attributable to the technical component of the service, plus the technical portion of the \$15.00 add-on for 2001 which is provided under the new legislation). Deductible applies. Coinsurance is 20 percent of the charge.

o HCPCS code G0206, Diagnostic mammography, direct digital image, unilateral, all views. Payment will be made based on the same amount that is paid to the provider, under the payment method applicable to the specific provider type (i.e., hospital, rural health clinic, etc.) for CPT code 76090, the code for a mammogram, one breast. For example, this service, when furnished as a hospital outpatient service, will be paid the amount under the outpatient prospective payment system (OPPS) for CPT code 76090. Deductible applies. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital.

o HCPCS code G0207, Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all view. Payment will be based on the same amount that is paid to the provider, under the payment method applicable to the specific provider type (i.e., hospital, rural health clinic, etc.) for CPT code 76090, the code for mammogram, one breast. For example, this service, when furnished as a hospital outpatient service, will be paid the amount payable under the OPPS for CPT code 76090. Deductible applies. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital.

B. Payment Requirements for Services Furnished on or After January 1, 2002.--Payment will be made as follows:

Code G0202 Payment will be equal to the lower of the actual charge or the locality specific technical component payment amount under the MPFS when performed in a hospital outpatient department, CAH, or SNF. Coinsurance is 20 percent of the lower amount, the Program pays 80 percent.

Deductible does not apply.

Code G0204 Payment will be made under OPPS for hospital outpatient departments. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital. Payment will be made on a reasonable cost basis for CAHs and coinsurance is based on charges. Payment is made under the MPFS when performed in a SNF and coinsurance is 20 percent of the lower of the actual charge or the MPFS amount.

Deductible applies.

Code G0206 Payment will be made under OPPS for hospital outpatient departments. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital. Payment will be made on a reasonable cost basis for CAHs and coinsurance is based on charges. Payment is made under the MPFS when performed in a SNF. Coinsurance is 20 percent of the lower of the actual charge or the MPFS amount.

Deductible applies.

You were furnished with a mammography benefit pricing file and record layout via Program Memorandum (PM) A-01-104, dated August 23, 2001, CR 1811. Use this pricing file to pay claims containing the above codes.

For CAHs, see §3610.22 for those that have elected the optional method of payment for outpatient services. For code G0202, see §3660.10B and for codes G0204 and G0206, see §3660.19.

C. Billing Requirements.--Providers bill for the technical portion of screening and diagnostic mammograms on Form HCFA-1450 under bill type 14X, 22X, 23X, or 85X. The professional component is billed to the carrier on Form CMS-1500 (or electronic equivalent).

Providers bill for digital screening mammographies on Form HCFA-1450, utilizing revenue code 403 and HCPCS G0202 or G0203.

Providers bill for digital diagnostic mammographies on Form HCFA-1450, utilizing revenue code 401 and HCPCS G0204, G0205, G0206 or G0207.

**NOTE:** Codes G0203, G0205 and G0207 are not billable codes for claims with dates of service on or after January 1, 2002.

HCPCS codes 76092 (screening mammography-film) and G0202 or G0203 (screening mammography-digital) should not be billed together since only one type of screening mammography will be paid. Therefore, advise your providers not to submit claims reflecting both a film screening mammography (76092) and a digital screening mammography (G0202 or G0203). Also advise your providers not to submit claims reflecting HCPCS codes 76090 or 76091 (diagnostic mammography-film) and G0204 or G0206 (diagnostic mammography-digital). Install an edit in your system to return claims to the provider when both a film and digital screening or diagnostic mammography are reported.

D. Billing and Payment of Computer Aided Detection (CAD) Services.--Code 76085, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography", for CAD has been established as an add on code that can be billed in conjunction with primary service code G0202. Payment will be made under the MPFS for code 76085. There is no Part B deductible. However, coinsurance is applicable. (See §3660.10B for billing and payment of CAD when billed in conjunction with a film screening mammogram.)

Return to provider claims containing code 76085 that do not also contain code G0202 with an explanation that payment for code 76085 cannot be made when billed alone.

Code G0236, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography", for CAD has been established as an add on code that can be billed in conjunction with primary service code G0204 or G0206. For code G0236, payment will be made under OPPS for hospital outpatient departments, on a reasonable cost basis for CAHs and under the MPFS for SNFs. The Part B deductible and coinsurance apply. (See §3660.19 for billing and payment of CAD when billed in conjunction with a film diagnostic mammogram.)

Return to provider claims containing code G0236 that do not also contain code G0204 or G0206 with an explanation that payment for code G0236 cannot be made when billed alone.

**NOTE:** Add-on codes cannot be billed by themselves. They must be accompanied by one of the other mammography codes. Add-on code 76085 must be billed with 76092 or G0202. Add-on code G0236 must be billed with 76091, G0204 or G0206.

### 3661. HOSPITAL OUTPATIENT PARTIAL HOSPITALIZATION SERVICES

Medicare Part B coverage is available for hospital outpatient partial hospitalization services. (See §3112.7.D for a description of services covered under this benefit.)

A. Billing Requirements.--Section 1861(ff) of the Act defines the services covered under the partial hospitalization benefit in a hospital or critical access hospital (CAH) outpatient setting. However, no separate payment methodology for these services is mandated. Therefore, in order to make proper payment, hospitals and CAHs are required to component bill for any service provided under this benefit.

Under component billing, hospitals and CAHs are required to report a revenue code and the charge for each individual covered service furnished under a partial hospitalization program. In addition, hospital outpatient departments are required to report HCPCS codes. CAHs are not required to report HCPCS codes for this benefit. Billing as individual services assures that only those partial hospitalization services covered under §1861(ff) of the Act are paid by the Medicare program.

Hospital outpatient departments bill you for partial hospitalization services on the Form HCFA-1450 (or electronic equivalent) under bill type 13X or 14X as appropriate. CAH outpatient departments bill under 85X. Follow bill review instructions in §3604 with the following exceptions.

Bills must contain an acceptable revenue code. They are as follows:

<u>Revenue Code</u>	<u>Description</u>
250	Drugs and Biologicals
43x	Occupational Therapy
904	Activity Therapy
910	Psychiatric/Psychological Services
914	Individual Therapy
915	Group Therapy
916	Family Therapy
918	Testing
942	Education Training

Hospitals and CAHs are required to report condition code 41 in FLs 24-30 to indicate the claim is for partial hospitalization services.

Hospitals other than CAHs are also required to report appropriate HCPCS codes as follows:

<u>Revenue Code</u>	<u>Description</u>	<u>HCPCS Code</u>
43X	Occupational Therapy	*G0129
904	Activity Therapy (Partial Hospitalization)	**G0176
910	Psychiatric General Services	90801, 90802, 90875, 90876, 90899, or 97770
914	Individual Psychotherapy	90816, 90818, 90821, 90823, 90826, or 90828
915	Group Psychotherapy	90849, 90853, or 90857
916	Family Psychotherapy	90846, 90847, or 90849
918	Psychiatric Testing	96100, 96115, or 96117
942	Education Training	***G0177

Edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. Do not edit for the matching of revenue code to HCPCS.

\*The definition of code G0129 is as follows:

“Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per day,”

\*\*The definition of code G0176 is as follows:

“Activity therapy, such as music dance, art or play therapies not for recreation, related to the care and treatment of patient’s disabling mental health problems, per session (45 minutes or more).”

\*\*\*The definition of code G0177 is as follows:

“Training and educational services related to the care and treatment of patient’s disabling mental health problems, per session (45 minutes or more).”

Revenue code 250 does not require HCPCS coding. However, drugs that can be self-administered are not covered by Medicare.

B. Professional Services.--The professional services listed below when provided in a hospital or CAH outpatient department are separately covered and paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PA) bill the Medicare Part B carrier directly for the professional services furnished to hospital outpatient partial hospitalization patients. The hospital or CAH can also serve as a billing agent for these professionals by billing the Part B carrier on their behalf under their billing number for their professional services. The professional services of a PA can be billed to the carrier only by the PAs employer. The following direct professional services are unbundled and not paid as partial hospitalization services.

- o Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;
- o Physician assistant (PA) services as defined in §1861(s)(2)(K)(i) of the Act;
- o Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act; and
- o Clinical psychologist services as defined in §1861(ii) of the Act.

The services of other practitioners (including clinical social workers and occupational therapists), are bundled when furnished to hospital or CAH patients, including partial hospitalization patients. The hospital must bill you for such nonphysician practitioner services as partial hospitalization services. Make payment for the services to the hospital or CAH.

PA services can only be billed by the actual employer of the PA. The employer of a PA may be such entities or individuals such as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the hospital or CAH, the physician and not the hospital would be responsible for billing the carrier on Form CMS-1500 for the services of the PA. (See Medicare Carriers Manual (MCM), §16001.)

C. Outpatient Mental Health Treatment Limitation.--The outpatient mental health treatment limitation may apply to services to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CNSs, and PAs to partial hospitalization patients. However, the outpatient mental health treatment limitation does not apply to such mental health treatment services billed to the intermediary by a CMHC, hospital, or CAH outpatient department as partial hospitalization services.

D. Reporting of Service Units.--Visits should no longer be reported as units by hospitals other than CAHs. Instead, hospital outpatient departments are required to report in FL 46, "Service

Units," the number of times the service or procedure, as defined by the HCPCS code, was performed when billing for partial hospitalization services identified by revenue codes in subsection C.

**EXAMPLE:** A beneficiary received psychological testing (HCPCS code 96100 which is defined in 1 hour intervals) for a total of 3 hours during 1 day. The hospital reports revenue code 918 in FL 42, HCPCS code 96100 in FL 44, and three units in FL 46.

When reporting service units for HCPCS codes where the definition of the procedure does not include any reference to time (either minutes, hours or days), hospital outpatient departments do not bill for sessions of less than 45 minutes.

You must RTP claims that contain more than one unit for HCPCS codes G0129, Q0082, and G0172 or that do not contain service units for a given HCPCS code.

**NOTE:** Service units are not required to be reported for drugs and biologicals (Revenue Code 250).

CAHs report the number of visits in FL 46 "Service Units".

E. Line Item Date of Service Reporting.--Hospitals other than CAHs are required to report line item dates of service per revenue code line for partial hospitalization claims. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in FL 45 "Service Date" (MMDDYY). See examples below of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

For the UB-92 flat file, report as follows:

<u>Record Type</u>	<u>Revenue Code</u>	<u>HCPCS</u>	<u>Dates of Service</u>	<u>Units</u>	<u>Total Charges</u>
61	915	90849	19980505	1	\$ 80.00
61	915	90849	19980529	2	\$160.00

For the hard copy UB-92 (HCFA-1450), report as follows:

<u>FL42</u>	<u>FL44</u>	<u>FL45</u>	<u>FL46</u>	<u>FL47</u>
915	90849	050598	1	\$ 80.00
915	90849	052998	2	\$160.00

For the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report as follows:

```
LX*1~
SV2*915*HC:90849*80*UN*1~
DTP*472*D8*19980505~
LX*2~
SV2*915*HC:90849*160*UN*2~
DTP*472*D8*19980529~
```

You must RTP hospital claims where a line item date of service is not entered for each HCPCS code reported by hospitals, or if the line item dates of service reported are outside of the statement covers period. Line item date of service reporting is effective for claims with dates of service on or after June 5, 2000.

F. Payment.--For hospital outpatient departments, make payment on the reasonable cost basis until August 1, 2000.

During the year, make payment at an interim rate based on a percentage of billed charges. Information applicable to determining interim rates for partial hospitalization services furnished as hospital outpatient services are contained in §§2400ff of the Provider Reimbursement Manual. Beginning with services provided on or after August 1, 2000, make payment under the hospital outpatient prospective payment system for partial hospitalization services. Hospitals must continue to maintain documentation to support medical necessity of each service provided, including beginning and ending time.

For CAHs make payment on a reasonable cost basis, regardless of the date of service.

Apply Part B deductible, if any, and coinsurance.

G. Data for CWF and PS&R.--Include revenue codes, HCPCS/CPT codes, units, and covered charges in the financial data section (fields 65a - 65j), as appropriate. Report the billed charges in field 65h, "Charges," of the CWF record.

Include in the financial data portion of the PS&R UNIBILL, revenue codes, HCPCS/CPT codes, units, and charges, as appropriate.

H. Medical Review.--Follow medical review guidelines in §3920.1.K3.

### 3662. BILLING FOR HOSPITAL OUTPATIENT SERVICES FURNISHED BY CLINICAL SOCIAL WORKERS (CSWs)

Payment is made for covered diagnostic and therapeutic services furnished by CSWs in a hospital outpatient setting. (See MCM, §5113 for an explanation of how payment is made and §2152 for CSW licensure and educational requirements.)

A. Fee Schedule To Be Used for Payment of CSW Services.--The fee schedule for CSW services is set at 75 percent of the fee schedule for comparable services furnished by clinical psychologists.

B. Payment Limitation.--CSW services are subject to the outpatient mental health treatment limitation in §1833 of the Act. Carriers apply the limitation of 62.5 percent to the lesser of the actual charge or fee schedule amount. Diagnostic services are not subject to the limitation. (See MCM, §2152 for more detail regarding the payment limit.)

C. Coinsurance and Deductible.--The annual Part B deductible and the 20 percent coinsurance apply to CSW services.

D. Billing.--

1. Hospital and CAH Outpatient Services.--CSWs do not bill directly for these services. Hospital and CAH outpatient services are bundled and hospitals bill the carrier for the services on Form CMS-1500 (or electronic equivalent). These services are not billed to you.

2. Partial Hospitalization Services.--CSW services furnished under the partial hospitalization program are also bundled for hospitals and CAHs. However, the hospital bills you for the services. Make payment on a reasonable cost basis. (See §3661 for an explanation.)

### 3663. OUTPATIENT OBSERVATION SERVICES

A. Observation Services.--Observation services are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible

admission as an inpatient. Such services are covered only when provided by order of a physician or another individual authorized by State licensure law and hospital bylaws to admit patients to the hospital or to order outpatient tests. Observation services usually do not exceed one day. Some patients, however, may require a second day of outpatient observation services. Observation services exceeding 48 hours will be denied. (See §3112.8.)

A hospital which believes that exceptional circumstances in a particular case justify approval of additional time in outpatient observation status may request an exception to the denial of services from you. See §3112.8E for procedures for requesting an exception.

The hospital will bill for observation services using the following revenue code.

<u>Revenue Code</u>	<u>Description</u>
762	Observation Services

For observation services, the hospital should report the number of hours in the units field. They should begin counting when the patient is placed in the observation bed. If necessary, they should verify the time in the nurses' notes. Round to the nearest hour. For example, a patient who was placed in an observation bed at 3:03 p.m. according to the nurses' notes and discharged to home at 9:45 p.m. should have a "7" placed in the units field.

B. Services Not Covered as Observation Services.--See §3112.8E for noncovered services. If the hospital has provided noncovered services, and given proper notification to the beneficiary, it will show only those charges associated with covered services. If the hospital provided more than 48 hours of observation, but thinks that the additional hours qualify for coverage, they will show all hours in the units field. Suspend the claim for documentation of the medical necessity of all observation services. If any such services are denied, the beneficiary cannot be held liable for payment.

Include in the financial data portion of the PS&R UNIBILL, revenue codes, HCPCS/CPT codes, units, and charges, as appropriate.